RATE YEAR 2006 OBRA'93 DATA COLLECTION FORM
(Information based upon hospital's fiscal year 2003 cost reporting period)

(Response required by August 15, 2005)

This form will be REJECTED if not completed in its entirety.

HOSPITAL: _____

CITY / STATE: _____

ALL COST REPORTING HOSPITALS MUST SUBMIT THE FOLLOWING INFORMATION FOR THE HOSPITAL'S
2003 COST REPORTING PERIOD: BEGIN DATE: _____ **END DATE:** _____ **, 2003**

	INPATIENT	OUTPATIENT (1)	TOTAL
1. Illinois Medicaid Charges: (excluding charges for Medicaid MCO clients)			
2. a. Hospital charity care charges for services provided to individuals without health insurance or other source of third party coverage: (2) (3) (out of state hospitals provide Illinois only)			
b. Hospital bad debt less any recoveries for services provided. Do not include charges reported under charity care above: (2)			
All Patients: (out of state hospitals provide Illinois only)			
Insured Patients Only: (out of state hospitals provide Illinois only)			
Net Bad Debt for Uninsured Patients: (3) (all patients minus insured patients)			
3. Illinois Total Hospital Charges: (4)			

(1) Includes hospital outpatient services and hospital based clinic services only.

(2) Do not include contractual allowances, or the hospital's charges attributable to services provided under its obligation pursuant to the federal Hill-Burton Act.

State or unit of local government payments made to a hospital on behalf of indigent patients (i.e. Transitional Assistance and State Family and Children Assistance) shall not be considered to be a form of insurance or a source of third party coverage. Therefore, unreimbursed charges for persons covered under these programs may be included.

(3) Federal law requires the collection of charity care and bad debt for uninsured patients only.

(4) Hospital charges includes all financial classes.

I CERTIFY that to the best of my knowledge the above information is true and correct.

The above information is based upon: ☐ audited financial statements and supporting schedules.

(please check the box that applies) ☐ unaudited financial statements and supporting schedules.

This form must be submitted to:
Illinois Department of Public Aid
Bureau of Health Finance
Hospital Audit Section
201 South Grand Avenue East - 2nd Floor
Springfield, Illinois 62763-0001
Phone (217)782-1630 Fax (217)782-2812

_____
Authorized Signature

_____
Name (Typewritten)

_____
Title (Typewritten)

_____ ( )
Date Phone

Completion of this form or compliance with instructions is voluntary; however failure to do so may affect this Department's action. Form approved by the Forms Management Center.